OCCUPATIONAL MEDICINE CLINIC

**16125 CAIRNWAY DR. SUITE 106**
**HOUSTON, TX 77084**
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**www.occmedicineclinic.com**

# AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I _____ authorize
Full legal name of Patient

_____
Name of Hospital/Physician/Facility

To release to: _____
Specific name of Hospital, Physician, Service Agency, or Third Party

_____
Street City State Zip Code

For the purpose of _____ _____
State specific reason Dates / Types of Service

_____ _____
Patient's Date of Birth Social Security Number

**The following specific information from my Medical Record:**

| | | | | | |
|---|---|---|---|---|---|
| _____ | Discharge Summary | _____ | X-Ray Reports | _____ | X-Ray Films |
| _____ | History & Physical | _____ | Alcohol and/or drug abuse information (See 1 below) | | |
| _____ | Occ Med Clinic Records | _____ | HIV – related information (See 2 below) | | |
| _____ | ER Records | _____ | Operative Report | | |
| _____ | Lab Reports | _____ | Other: Specific: _____ | | |

1. Confidentiality of **DRUG/ALCOHOL ABUSE** records are protected by Federal Regulations **(42 CFR, Part 2)**

2. Confidential **HIV-RELATED INFORMATION** is any information that is likely to identify, directly or indirectly, someone as having been tested for or actually having HIV infection. Antibodies to HIV, AIDS, or related infections or illness, or someone suspected of having HIV as a result of high risk activities. **PATIENT DOES NOT HAVE TO AUTHORIZE RELEASE OF HIV-RELATED INFORMATION.**

I DO NOT authorize release of HIV-related information _____
Name Date

I understand that I may revoke this consent at any time by providing written notice of revocation to the Occupational Medicine Clinic. This authorization shall expire 180 days from date it is signed, unless sooner revoked, but not retroactive to the release of information made in good faith; and further, that upon fulfillment of the above-stated purpose, this consent will automatically expire without my express revocation. I understand that my refusal to sign or revocation of this authorization will not affect the commencement, continuation, or quality of my treatment at the Occupational Medicine Clinic except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, in which case the Occupational Medicine Clinic may refuse to treat me if I do not sign this authorization.

I understand that the Occupational Medicine Clinic may, directly or indirectly, receive remuneration for a third party in connection with the use or disclosure of my health information.

I understand that once the Occupational Medicine Clinic discloses my information to the recipient, the Occupational Medicine Clinic cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.

To the Party receiving this information: This information has been disclosed to you from the records whose confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2 AND ALL OTHER PATIENTS.

Signed: _____ Date: _____

Relationship if signed by other than Patient: _____

Witness: _____ Date: _____